



January 16, 2019

**INFORMATION MEMO FOR CHARGÉ LAPENN, SOUTH AFRICA**

**FROM: S/GAC – Ambassador Deborah L. Birx, MD**

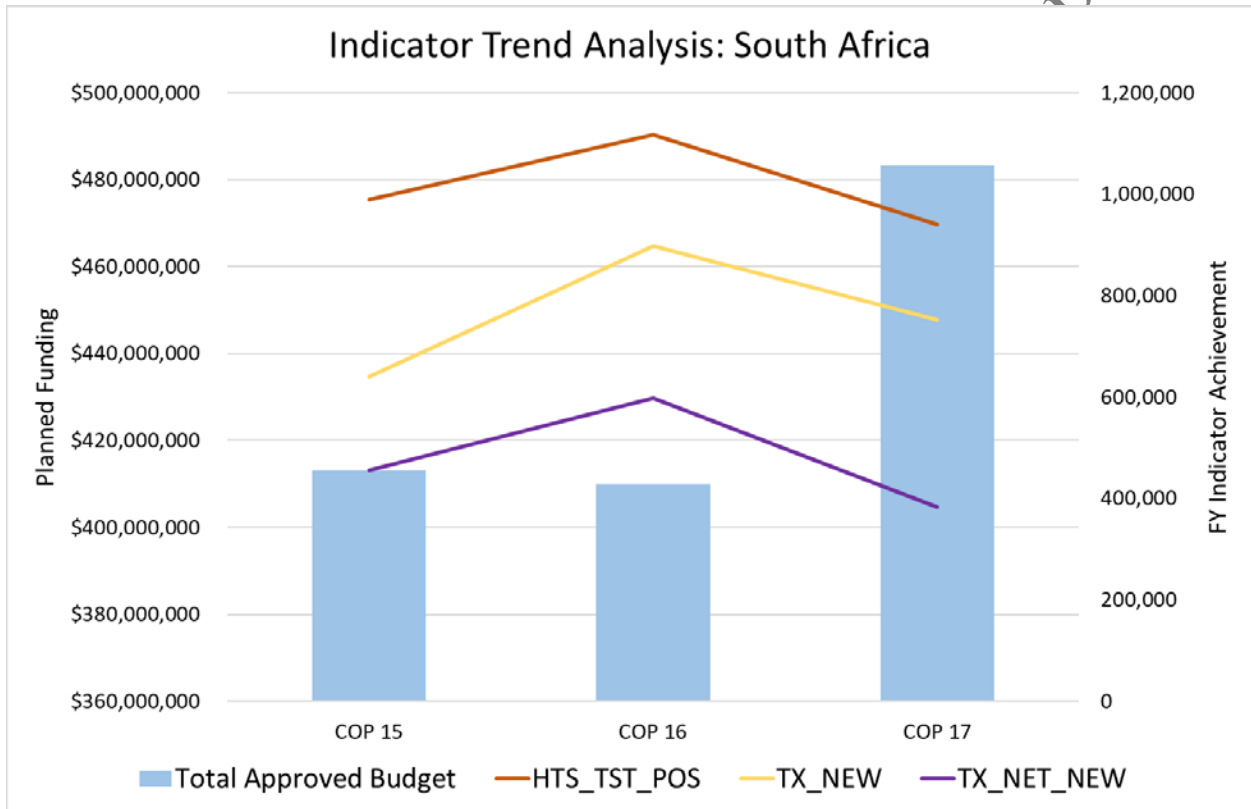
**SUBJECT: FY 2019 PEPFAR Planned Allocation and Strategic Direction**

We are grateful to you, Chargé Lapenn, and your Deputy Chief of Mission, for your engagement in planning, review and implementation, and with the community and Government to enhance PEPFAR program impact. We are grateful for your attention to core policy adoption and to holding partners to account for their expenditures and performance. In addition, we are grateful for your PEPFAR staff's technical expertise, interagency collaboration and program implementation acumen to ensure the efficient use of U.S. taxpayer dollars.

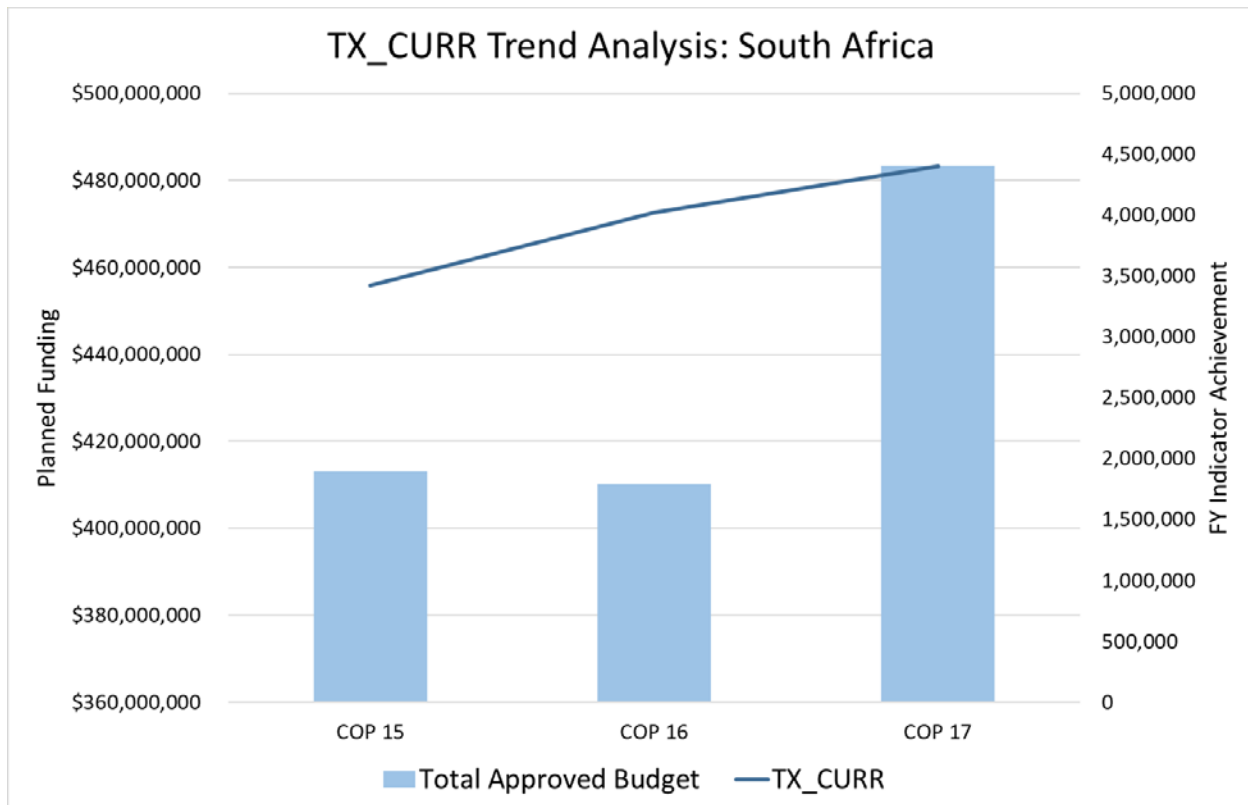
The U.S. Government, through PEPFAR, is proud to partner with the people and Government of South Africa in accelerating South Africa's progress towards achieving HIV/AIDS epidemic control. With a total bilateral investment of \$6,228,892,684 from FY 2004 – FY 2019, PEPFAR has been committed to accelerating the country's progress toward epidemic control. In FY 2018, the PEPFAR team worked together with the Government of South Africa (GoSA) to identify 939,704 people living with HIV (PLHIV) and started 752,934 new patients on treatment, resulting in 4,405,372 million PLHIV currently on treatment across all 52 districts. We were encouraged by President Ramaphosa's call to action to initiate 2 million more people on antiretroviral treatment by 2020 – and demonstrated our support and commitment with additional resources through the Surge Plan to accelerate HIV testing, treatment, and retention. DREAMS has shown marked progress in FY 2018 and OVC results surpassed its FY 2018 target, reaching 661,481 beneficiaries, of which 45% were adolescent girls and young women (AGYW) ages 10-24. Operation 10-10, an intensive partner management action plan that was launched in the summer of 2018 to resolve challenges at the largest volume sites in the highest burden districts, has already begun to demonstrate preliminary solutions to address retention challenges experienced throughout the program.

While we celebrate these successes, we also note several fundamental problems in PEPFAR's core treatment program in South Africa. Despite a significant infusion of resources by the U.S. government especially over the last three years, progress has been grossly sub-optimal and insufficient to reach epidemic control, including the targets of the Surge Plan. The PEPFAR program has demonstrated extremely poor performance in ensuring every person who is started on treatment is retained, particularly from FY 2017 to FY 2018 where results have been relatively stagnant at 479,912 to 481,014 respectively, despite an increase in resources. In fact, the PEPFAR program lost more people on treatment than it gained in FY 2018. Across PEPFAR/South Africa programming, FY 2018 overspending and underperformance at the partner level is a program management and oversight issue. Overall, TX\_NET\_NEW achieved

only 25% of its overall targets in FY 2018, with a total of 299,542 NET NEW across PEPFAR supported sites. Poor oversight during partner transitions contributed to the huge loss in these results. The full expenditure of PEPFAR resources without improvement of results is unacceptable. This represents a serious, continued problem and program failure – linkage and retention must improve in South Africa now in COP 2018 implementation. We commend the PEPFAR team’s remediation actions that are already underway for COP 2018– such as the termination of implementing partner Foundation for Professional Development, a complete agency oversight transition from USAID to CDC in Tshwane, and an intensification of weekly management and reporting through Operation 10-10. South Africa requires an urgent and transformative response in both GoSA engagement and enabling policies and PEPFAR programming to reach epidemic control by 2020.



Subject



\*The graphics above include Implementing Mechanism 16772- the South Africa National Department of Health

Based on the above graphics, the United States resources are not leading to greater impact. Significant improvements must be made in COP 2018 execution, to result in either continued surge funding, or any increases to the COP 2019 planning level.

It is critical that we establish a sound treatment program before we move to add new patients into the program. In COP 2018, PEPFAR/South Africa must hold on all testing and active case finding until the linkage and retention issues improve. For COP 2019, treatment targets will be straight lined from FY 2018 results. If PEPFAR/South Africa demonstrates performance improvement across the treatment clinical cascade, particularly addressing the severe linkage and retention issues through transformative shifts to program implementation, additive COP 2019 funds will be unlocked for FY 2020 implementation.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) total planning level for South Africa for the 2019 Country Operational Plan (COP 2019) is **\$400,000,000**, inclusive of all new funding accounts and applied pipeline.

If you have questions about the priorities and guidance laid out in this letter, please contact your Chair, Angeli Achrekar and Program Manager, Maureen Ahmed. My office is continually grateful for your team's work on the PEPFAR program, helping us to move together with the GoSA towards epidemic control in South Africa.

**APPENDICES:**

- 1. COP 2019 PLANNING LEVEL**
- 2. COP 2019 BUDGETARY REQUIREMENTS & GUIDANCE**
- 3. PAST PERFORMANCE**
- 4. COP 2019 DIRECTIVES**

*Subject to COP Development and Approval*

## APPENDIX 1: COP 2019 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the FY 2018 Q4 POART and performance information, the total COP 2019 planning level is estimated to be comprised as follows:

**Table 1. COP 2019 Budget**

South Africa	
TOTAL COP 2019 PLANNING LEVEL: \$400,000,000	
Total Base Budget for COP 2019 Implementation	\$ 400,000,000
Total COP 19 New Funding	\$ 364,148,220
of which, VMMC	\$ 60,278,659
of which, DREAMS	\$ 33,323,381
Total Applied Pipeline	\$ 35,851,780

**Table 2. Applied Pipeline**

South Africa	
COP 2019 Applied Pipeline By Agency	
Total Applied Pipeline	\$ 35,851,780
HHS/CDC	\$ 19,449,133
DOD	\$ 2
PC	\$ 894,542
State	\$ 222,994
USAID	\$ 15,285,110

\*VMMC funding may be used from applied pipeline or new funds.

\*\*Based on agency reported available pipeline from EOFY

All planning levels are subject to further adjustment, **based upon appropriations**, further analysis determining the availability of excessive pipeline, and other developments during the course of COP 2018 implementation and the COP 2019 review process. The total spend in the implementation of COP 2019 (FY 2020) may not exceed the total COP 2019 planning level of \$400,000,000.

## APPENDIX 2: COP 2019 BUDGETARY REQUIREMENTS

Table 3. COP 2019 Earmarks

South Africa	
COP 2019 EARMARK REQUIREMENTS	
Care and Treatment (C&T)	\$ 238,884,766
<i>% of base funds allocated to C&amp;T</i>	<i>66%</i>
HKID	\$ 27,869,889
Gender Based Violence (GBV)	\$ 4,603,226
Water	\$ 1,500,000

Care and Treatment: If there is no adjustment to the COP 2019 new funding level due to an adjustment in applied pipeline, South Africa's minimum requirement for the care and treatment earmark is reflected in the chart above. Your care and treatment requirement is calculated as the sum of total new FY 2019 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS budget codes, 30% of the total funding programmed to the MTCT budget code, 80% of the total funding programmed to the HLAB budget code, and 30% of the total funding programmed to the HVCT budget code. This minimum care and treatment earmark has been derived based upon a requirement that your country programs a minimum of 66% of all **new FY 2019 Base Funds** to care and treatment of people living with HIV.

HKID Requirement: South Africa's COP 2019 minimum requirement for the HKID budget code is reflected in the chart above. Your COP 2019 HKID requirement is derived based upon the approved COP 2018 HKID level. The COP 2019 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

Gender Based Violence (GBV): South Africa's COP 2019 minimum requirement for the GBV earmark is reflected in the chart above. Your GBV earmark requirement is calculated as the total **new FY 2019** funding programmed to the GBV cross-cutting code. Your COP 2019 earmark is derived by using the final COP 2018 GBV earmark allocation as a baseline. The COP 2019 planned level of new FY 2019 funds for GBV can be above this amount; however, it cannot fall below it.

Water: South Africa's COP 2019 minimum requirement for the water earmark is reflected in the chart above. Your water earmark requirement is calculated as the total **new FY 2019 funding** programmed to the water cross-cutting code. Your COP 2019 earmark is derived by using the final COP 2018 water earmark allocation as a baseline. The COP 2019 planned level of new FY 2019 funds for water can be above this amount; however, it cannot fall below it.

Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of

these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. PEPFAR has set a 70% goal **by agency** by the end of FY20 and must meet 40% by FY19. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each South Africa agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY20 as appropriate through their COP 2019 submission.

### **COP 2019 Applied Pipeline**

All agencies in South Africa should hold a 3-month pipeline at the end of COP 2019 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP 2018 implementation (end of FY 2019) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP 2019, decreasing the new funding amount to stay within the planning level.

The Applied Pipeline amount of \$35,851,780 given by S/GAC as a part of the COP 2019 planning level has been calculated to reflect the projected excessive pipeline as of the beginning of the COP 2019 implementation cycle (FY 2020) and is the minimum amount that South Africa must apply as pipeline in the COP 2019 submission. The pipeline was calculated by summing the outlays in excess of the COP 2017 planning levels having processed all approved OPUs. As per guidance, Agencies are expected to plan for outlays that are projected to occur during the COP year, including outlays that are for close out, reconciliations, reimbursements, and no cost extensions. Therefore, these outlays in excess of the planning level should have been approved through an OPU which then reduced funding available to the other IMs. As this was not done for COP 2017, it will need to be done in COP 2019 by managing COP 2018 outlays so that it is available to apply as pipeline in COP 2019.

The distribution of new base funds and Applied Pipeline was calculated to ensure 3 months of pipeline remains with mechanisms, based upon the financial data submitted for the FY 2018 Q4 Obligation and Outlay and FY 2018 End of Fiscal Year (EOFY) reports. Expired funds, funds on expired mechanisms and projected FY 2019 outlays as submitted in the EOFY report were all taken into consideration to inform the projected excessive pipeline and the required COP 2019 applied pipeline amount.

Unliquidated obligations on closed mechanisms identified in the FY 2018 EOFY report should be de-obligated in a timely manner. This will continue to be monitored throughout FY 2019 (COP 2018 implementation) and into COP 2019.

**APPENDIX 3: PAST PERFORMANCE TRENDS**

**Table 4. COP 2017/ FY 2018 Outlays versus Approved Budget**

Row Labels	Sum of Approved COP 2017 Planning Level	Sum of Total FY 2018 Outlays	Sum of Over/Under Outlays
South Africa	\$ 483,323,381	\$ 428,394,024	\$ (54,929,357)
DOD	\$ 399,737	\$ 2,219,151	\$ 1,819,414
HHS	\$ 211,995,575	\$ 197,661,977	\$ (14,333,598)
PC	\$ 2,375,000	\$ 1,884,284	\$ (490,716)
State	\$ 4,800,256	\$ (7,741,440)	\$ (12,541,696)
USAID	\$ 263,752,813	\$ 234,370,052	\$ (29,382,761)
<b>Grand Total</b>	<b>\$ 483,323,381</b>	<b>\$ 428,394,024</b>	<b>\$ (54,929,357)</b>

\* State obligations and outlays have not yet been reconciled and the numbers in this table may change based on reconciliation.

**Table 5. IP FY18 Outlays**

\* This table was based off the FY18 EOFY submissions but edited to reflect OPU's as of January 15th, 2019. Agencies outlaid to the following Implementing Mechanisms 105% or more in excess of their COP17 approved planning level.

Mech ID	Prime Partner	Funding Agency	COP17/FY18 Budget (New funding + Pipeline)	Actual FY18 Outlays (\$)	Over/Under FY18 Outlays (Actual \$ - Total COP17 Budget \$)
N/A	N/A	HHS/CDC	\$ 15,795,690	\$ 17,293,578	\$ 1,497,888
9526	Partnership for Supply Chain Management	USAID	\$ -	\$ 9,062	\$ 9,062
11498	U.S. Peace Corps	PC	\$ 425,000	\$ 469,634	\$ 44,634
11500	U.S. Department of State	State/AF	\$ 1,595,446	\$ 1,872,966	\$ 277,520
12887	AIDS Foundation	HHS/CDC	\$ -	\$ 87,418	\$ 87,418
13558	Human Science Research Council of South Africa	HHS/CDC	\$ -	\$ 112,045	\$ 112,045
13585	Shout It Now	HHS/CDC	\$ -	\$ 109,123	\$ 109,123
13608	University of Washington	HHS/CDC	\$ -	\$ 103,717	\$ 103,717
13619	JHPIEGO	HHS/CDC	\$ -	\$ 730,699	\$ 730,699
13644	University of Cape Town	HHS/CDC	\$ -	\$ 15,144	\$ 15,144
13695	Epicentre AIDS Risk Management	HHS/CDC	\$ -	\$ 1,330,857	\$ 1,330,857
13771	Howard University	HHS/CDC	\$ -	\$ 148,697	\$ 148,697
13797	Health Systems Trust	HHS/CDC	\$ -	\$ 1,175,061	\$ 1,175,061



13800	Columbia University Mailman School of Public Health	HHS/CDC	\$ -	\$ 148,265	\$ 148,265
13888	Population Services International	HHS/CDC	\$ -	\$ 367,390	\$ 367,390
13902	Human Sciences Research Council	HHS/CDC	\$ -	\$ 895,811	\$ 895,811
13903	Community Media Trust	HHS/CDC	\$ -	\$ 147,072	\$ 147,072
14623	Foundation for Professional Development	USAID	\$ -	\$ 600,441	\$ 600,441
16583	Aurum Health Research	HHS/CDC	\$ -	\$ 647,522	\$ 647,522
16584	Beyond Zero	HHS/CDC	\$ -	\$ 295,542	\$ 295,542
16773	South African National AIDS Council	HHS/CDC	\$ 387,331	\$ 529,949	\$ 142,618
16807	University of Stellenbosch, South Africa	HHS/CDC	\$ 1,500,000	\$ 1,927,670	\$ 427,670
16980	University Research Corporation, LLC	USAID	\$ -	\$ 1,044,938	\$ 1,044,938
16993	NACOSA (Networking AIDS Community of South Africa)	USAID	\$ 641,864	\$ 727,880	\$ 86,016
17019	Anova Health Institute	USAID	\$ 2,344,226	\$ 2,698,933	\$ 354,707
17022	The South-to-South Partnership for Comprehensive Family HIV Care and Treatment Program (S2S)	USAID	\$ -	\$ 43,445	\$ 43,445
17023	Broadreach	USAID	\$ 18,219,118	\$ 23,026,986	\$ 4,807,868
17026	Mothers to Mothers (M2M)	USAID	\$ -	\$ 579,580	\$ 579,580
17033	Medical Research Council	HHS/CDC	\$ 3,130,056	\$ 5,191,354	\$ 2,061,298
17036	Foundation for Professional Development	USAID	\$ 12,732,443	\$ 18,193,860	\$ 5,461,417
17047	FHI 360	USAID	\$ -	\$ 1,131,278	\$ 1,131,278
17459	Human Sciences Research Council	HHS/CDC	\$ 410,000	\$ 3,479,953	\$ 3,069,953
17506	Beyond Zero	HHS/CDC	\$ 1,800,000	\$ 2,342,582	\$ 542,582
17507	Kheth'Impilo	HHS/CDC	\$ 2,325,000	\$ 2,892,533	\$ 567,533

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17512	World Health Organization	HHS/CDC	\$ 408,414	\$ 450,439	\$ 42,025
17767	Broadreach	HHS/CDC	\$ 300,000	\$ 877,314	\$ 577,314
17768	Columbia University Mailman School of Public Health	HHS/CDC	\$ 450,000	\$ 604,904	\$ 154,904
17769	University of Washington	HHS/CDC	\$ 4,175,000	\$ 6,168,616	\$ 1,993,616
18231	Population Services International/Society for Family Health	DOD	\$ 187,723	\$ 2,005,321	\$ 1,817,598
18298	Abt Associates	USAID	\$ 1,000,000	\$ 1,186,210	\$ 186,210
18307	UCSF CDC HQ	HHS/CDC	\$ 200,000	\$ 391,199	\$ 191,199
18314	National Alliance of State and Territorial AIDS Directors	HHS/CDC	\$ -	\$ 239,630	\$ 239,630

**Table 6. COP 2017/ FY 2018 Results versus Targets\***

\* Financial and target performance data not a one-to-one correlation as program classification expenditures encompass more than those towards indicator/target presented.

Agency	Indicator	FY18 Target	FY18 Result	% Achievement	Program Classification	FY18 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	3,665,207	3,557,040	97%	HTS	\$ 20,502,439	94%
	HTS_TST_POS	393,731	262,686	67%			
	TX_NEW	341,103	189,364	56%	C&T	\$ 58,712,420	78%
	TX_CURR	1,321,819	1,109,920	85%			
	VMMC_CIRC	341,215	271,142	79%	PREV: CIRC	\$ 25,445,583	100%
	OVC_SERV	83,424	56,480	68%	SE for OVC	\$ 3,021,063	100%
					Above Site Programs	\$ 37,412,146	
				Program Management	\$ 26,854,451		
USAID	HTS_TST	6,451,109	7,182,472	111%	HTS	\$ 34,122,917	100%
	HTS_TST_POS	591,307	505,557	85%			
	TX_NEW	701,005	431,549	62%	C&T	\$ 65,102,793	89%
	TX_CURR	3,089,154	2,380,315	77%			
	VMMC_CIRC	229,644	228,854	100%	PREV: CIRC	\$ 30,283,397	95%
	OVC_SERV	532,675	555,275	104%	SE for OVC	\$ 18,766,004	100%

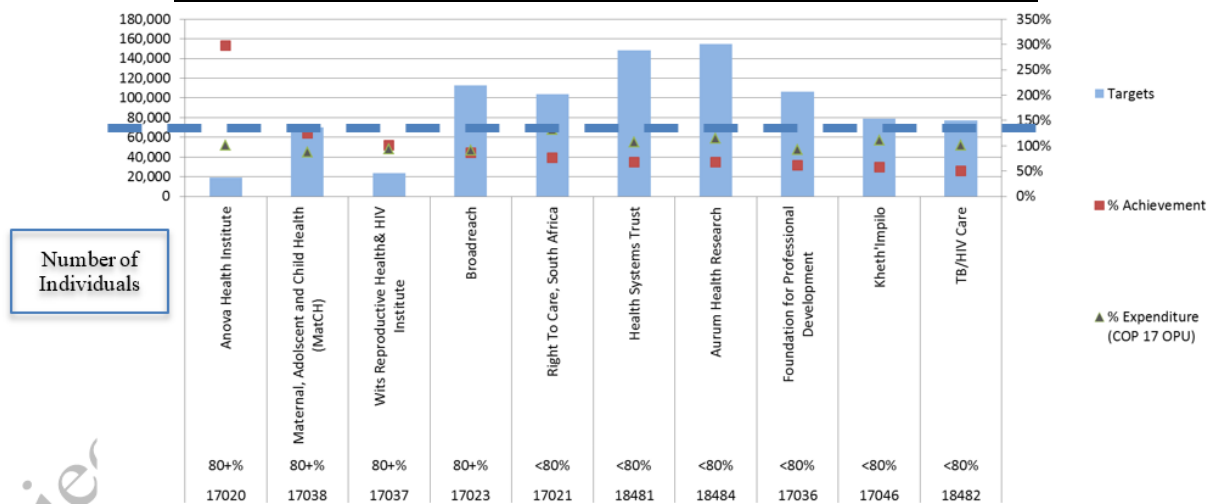
					<b>Above Site Programs</b>	\$ 36,378,182	
					<b>Program Management</b>	\$ 50,831,535	
DOD	HTS_TST	N/A	N/A	N/A	HTS	N/A	N/A
	HTS_TST_POS	N/A	N/A	N/A			
	TX_NEW	N/A	N/A	N/A	C&T	N/A	N/A
	TX_CURR	N/A	N/A	N/A			
	VMMC_CIRC	N/A	N/A	N/A	PREV: CIRC	\$ 228,438	100%
	OVC_SERV	N/A	N/A	N/A	SE for OVC		
					<b>Above Site Programs</b>	\$ 225,174	
					<b>Program Management</b>	\$ 216,833	
HRSA	HTS_TST	N/A	N/A	N/A	HTS	N/A	N/A
	HTS_TST_POS	N/A	N/A	N/A			
	TX_NEW	N/A	N/A	N/A	C&T	\$ 86,933	100%
	TX_CURR	N/A	N/A	N/A			
	VMMC_CIRC	N/A	N/A	N/A	PREV: CIRC	N/A	N/A
	OVC_SERV	N/A	N/A	N/A	SE for OVC	N/A	N/A
					<b>Above Site Programs</b>	\$ 2,551,177	
					<b>Program Management</b>	\$ 1,465,775	
PC	HTS_TST	N/A	N/A	N/A	HTS	N/A	N/A
	HTS_TST_POS	N/A	N/A	N/A			
	TX_NEW	N/A	N/A	N/A	C&T	N/A	N/A
	TX_CURR	N/A	N/A	N/A			
	VMMC_CIRC	N/A	N/A	N/A	PREV	\$ 468,753	100%
	OVC_SERV	1,800	1,105	61%	SE for OVC	N/A	N/A
					<b>Above Site Programs</b>	N/A	
					<b>Program Management</b>	\$ 881	
STATE/AF	HTS_TST	N/A	36,340	N/A	HTS	\$ 278,854	71%
	HTS_TST_POS	N/A	2,147	N/A			
	TX_NEW	N/A	N/A	N/A	C&T	\$ 151,332	100%
	TX_CURR	N/A	N/A	N/A			
	VMMC_CIRC	N/A	N/A	N/A	PREV: CIRC	N/A	N/A
	OVC_SERV	N/A	36,508	N/A	SE for OVC	N/A	N/A
					<b>Above Site Programs</b>	N/A	
					<b>Program Management</b>	N/A	

**COP 2017/ FY 2018 Performance**

**Overall**

- The PEPFAR/South Africa program has demonstrated sub-optimal progress across its entire clinical cascade targets. In the high burden 27 districts, the program did not achieve HTS\_TST\_POS, TX\_NEW, TX\_CURR, and TX\_NET\_NEW targets.
- The program exceeded its testing targets (HTS\_TST at 105% in the 27 high burden districts) and underachieving in identifying HIV positives (HTS\_TST\_POS at 79% in the 27 high burden districts). Over-testing while under-achieving on HTS\_TST\_POS, represents an excess of unfocused and non-targeted testing, as well as the need to increase volume of more effective testing modalities (i.e., testing of index contacts and presumptive TB clients).
- While HTS\_TST\_POS saw high achievement in the four highest burden districts, low yields (9.5%) persisted, suggesting that such testing is not being performed with fidelity (i.e., testing sexually- or parenterally-exposed partners or the biological children of index cases).
- With a PLHIV target of over 300,000, the highest volume partners underperformed against the HIV TST\_POS target. , including Right to Care (76%), Aurum (67%), HST (68%), and Kheth'Impilo (57%). Despite this underperformance, Aurum, Right to Care, and HST also overspent their budget.

**FY18 HTS TST POS % Achievement vs % Expenditure by IP**

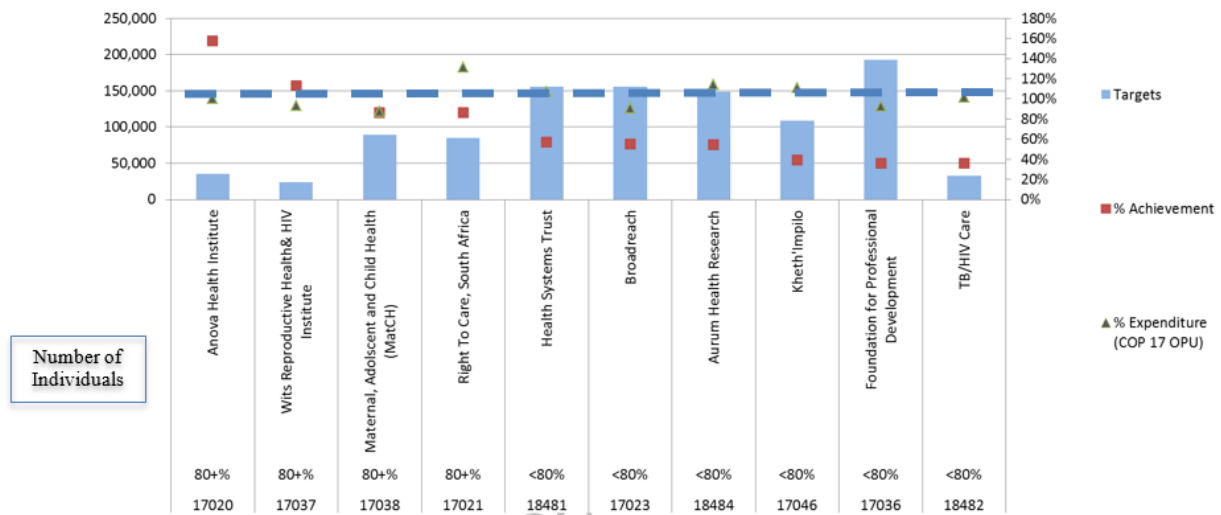


- Case finding performance was strong in four highest burden districts, with over 100% achievement of HTS\_TST\_POS in total and in each district. However, case finding results across all SNUs were too low to reach TX\_NEW targets. While linkage improved in the 27 focus districts to 87% in FY 2018 Q4, linkage overall only increased from 76% to 80% from FY 2017 to FY 2018 and was still below the target. The program is not on track to achieve its TX\_NEW targets and is losing a significant number of patients from TX, undercutting gains and retention continues to be a significant area of concern.
- The PEPFAR program has demonstrated extremely poor performance in ensuring every person who is started on treatment is retained, particularly from FY 2017 to FY 2018

where results have been relatively stagnant at 479,912 to 481,014 respectively, despite an increase in resources.

- Overall, TX\_NET\_NEW in the 27 focus districts was a total of 299,547 NET\_NEW for FY 2018. This is insufficient to reach Surge targets. Poor oversight during partner transitions led to loss in NET\_NEW results.
- Four implementing partners underperformed and overspent against the TX\_NEW target – including Aurum (62%), HST (57%), Broadreach (55%), and Kheth'Impilo (39%).

**FY18 TX\_NEW % Achievement vs % Expenditure by IP**



- Overall, retention and viral load suppression improved slightly from 2017 to 2018 and exceeded FY 2018 targets. While progress has been good across SNU and IPs, retention and attrition remain as major impediments to PEPFAR South Africa’s achievement of its treatment targets.
- Retention among those newly initiated on treatment was 76% in FY 2018, with the biggest challenges seen in adolescents and men – but still too low to reach treatment targets.
- Viral load suppression is at or near 79% in age groups <20 years, and ranges from 88-94% for age groups 20+ years.
- With the exception of USAID partners MatCH and Right to Care, majority of implementing partners saw a slight increase in viral load suppression from FY 2017 to FY 2018.

**Prevention**

- In FY 2018, voluntary medical male circumcision (VMMC) performance exceeded FY 2017 results by 57,000 circumcisions. However, FY 2018 Q4 results only resulted in overall 89% achievement. Targets achieved was due largely to excellent performance from USAID partner URC (110% achievement and spent under budget) and CDC partner Aurum (350% achievement). CDC partner TB/HIV expended its full budget with less than 20% achievement.

- PREP\_NEW remains terribly low – in FY 2018 the PEPFAR program only initiated 5,524 (or 29% of its target).

**Partner Performance**

- USAID partner Anova is performing exceptionally well across the entire clinical cascade.
- USAID partner Kheth'Impilo significantly underperformed across testing and treatment targets.
- With large volume targets, CDC partners Aurum and HST underachieved and overspent across the first and second 90.
- CDC partner TB/HIV underperformed across the entire clinical cascade. The partner has also underperformed and overspent on its VMMC targets.

Subject to COP Development and Approval

## APPENDIX 4: COP 2019 DIRECTIVES

**Table 7. COP 2019 (FY 2020) Targets**

Based on current progress towards epidemic control and funding level, the following FY 2020 treatment targets are recommended for South Africa:

Indicator	Pediatric (<15) Target	Adult (15+) Target	Target Total <sup>a</sup>
Revised COP 18 (FY 19 Targets)			
TX_NEW (New on Treatment)	15,597	558,815	574,412
TX_CURR (Current on Treatment)	127,447	3,861,464	3,988,911
TB_PREV	N/A	N/A	N/A
VMMC_CIRC	N/A	N/A	509,517
COP 19 (FY 20 Targets)			
TX_NEW (New on Treatment)	15,597	558,815	574,412
TX_CURR (Current on Treatment)	143,044	4,420,278	4,563,322
TB_PREV	N/A	N/A	834,022
VMMC_CIRC		306,800	520,000

<sup>a</sup>Targets should be further allocated by age and sex based on disaggregated PLHIV estimates and unmet need for ART.

These targets were developed based on the following assumptions:

- **TX\_NEW:** Targets for TX\_NEW assume that 90% of facility-based testing continues for the remainder of COP 2018, and into COP 2019, and that linkage rates improve substantially
- **TX\_CURR:** The revised TX\_CURR for FY 2019 for South Africa was set by adding the new TX\_NEW target for COP 2018 to TX\_CURR FY 2018 results, with the hope that South Africa can achieve this target by FY 2019. We then continued this for a second year, so that FY 2020 TX\_CURR is merely the additional of the same TX\_NEW target again.
- **TB\_PREV:** Targets for TB\_PREV were calculated using estimated number of patients expected to be on ART at the start of COP 2019 who would screen negative for TB symptoms, the proportion likely to be ineligible for clinical reasons, the estimated number who would have already received TPT by the start of COP 2019 and projected enrollment and completion rates.
- **VMMC\_CIRC:** Targets for VMMC were developed based on current coverage, past performance, and available funding for prevention activities.

Given the lack of linking and retaining new and current ART patients, some COP 2018 funds will need to be preserved by not scaling during the improvement period. Accordingly, FY 2019 treatment targets have been temporarily adjusted downward. The expectation is that only facility-based testing will continue during the improvement period. As fewer positives will now need to be diagnosed during COP 2018 implementation, a minimum of 30% of the testing budget from COP 2018 should be saved and applied as pipeline to use in COP 2019. This should be incorporated into pipeline amount determinations for the implementing partners who conduct testing in COP 2018 and COP 2019.

In COP 2018, PEPFAR/South Africa must hold on all testing and active case finding until the linkage and retention issues improve. For COP 2019, treatment targets will be straight lined

from COP 2018 results if PEPFAR South Africa demonstrates performance improvement across the clinical cascade through transformative shifts to program implementation, additive COP 2019 funds will be unlocked for FY 2020 implementation. Specifically, performance must improve across the treatment clinical cascade.

### COP 2019 Minimum Requirements

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements no later than the beginning of COP19 implementation (FY 2020). Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs. Failure to meet any of these requirements by FY 2020 will result in reductions to the South Africa budget. Adoptions and implementation of critical policies are required at the site/facility level U.S. government resources/investments must additive to partner government investments.

**Table 8. Minimum Requirements**

<b>Minimum Requirement</b>	<b>South Africa Specific Guidance</b>
1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups.	South Africa has adopted a Test and Start policy at all PEPFAR sites. The team should continue to work with NDoH to ensure rapid same day/same site ART initiation is occurring at the site level.
2. Adoption and implementation of differentiated service delivery models, including six month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents.	DSD for stable patients is extensive in South Africa, with options for ARV pick-up through external pick-up points, fast lanes, and through adherence clubs available nationally once a patient has been on ART for 12-months and has 2 suppressed VL's. Decanting rates are high, though challenges with data quality related to these modalities need to be addressed. Plans for DSD for patients with advanced disease must continue to be pursued as part of the effort to transition the Advanced Clinical Care program. The team should work with NDoH to ensure policy linking to treatment is being fully implemented across all geographic areas and age, sex, and risk groups.
3. Completion of TLD transition, including consideration for women of childbearing	Tenders are currently being awarded, with first shipment of TLD for broad use expected to arrive in July 2019. Extensive roll-out



<p>potential and adolescents, and removal of Nevirapine based regimens.</p>	<p>planned for mid-2019. The team should continue to engage with GoSA to ensure TLD transition for women of reproductive age gets included in the national guidelines.</p> <p>In the meantime, the team should continue to use remaining TLE stock and complete its TLD transition in COP19. After the transition, South Africa should consider “decanting” with single VL&lt;1000.</p>
<p>4. Scale up of Index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established.</p>	<p>Policies scaling up index testing and self-testing are adopted at the site level. NDoH should create a SOP for index testing guidance that can be implemented at the provincial and district levels. The team should scale up index partner testing and self-testing to maximize case-finding and optimize the cost per positive.</p>
<p>5. TB preventive treatment (TPT) for all PLHIVs must be scaled-up as an integral and routine part of the HIV clinical care package.</p>	<p>Team should continue to scale TB preventative therapy for all eligible PLHIV and TB PREV targets should reflect TPT as routine part of clinical cascade.</p> <p>The team should also continue to monitor current guidelines discussions regarding whether pregnant women should continue to receive TPT, given recent safety concerns, as well the exploration of introducing 3HP.</p>
<p>6. Direct and immediate (&gt;95%) linkage of clients from testing to treatment across age, sex, and risk groups.</p>	<p>COP19 IP work plans need to reflect fidelity to this minimum requirement. Special attention should be paid to linkage in the 10-14 age bands and AGYW.</p>
<p>7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC and TB services, affecting access to HIV testing and treatment and prevention.</p>	<p>User fees are not a significant barrier in South Africa.</p>
<p>8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups.</p>	<p>VL coverage generally increases with age but remains under 75% in all age groups. VL suppression also increases by age and ranges from 75-80% in childhood and adolescence.</p>
<p>9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.</p>	<p>As a continuation of systems level investments, systems to monitor morbidity and mortality should be prioritized.</p>

<p>10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14-year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management.</p>	<p>Maintain its year-on-year improvement of testing and linking eligible OVC (0-17) and continue to monitor its OVC transition.</p>
<p>11. Evidence of resource commitments by host governments with year after year increases.</p>	<p>The GoSA contributes significantly to its HIV response, at 75-80% and has aligned its investment with the U.S. government for maximum impact. The team should continue to work with GoSA to increase domestic resources to increase access to HIV prevention and treatment services for all persons.</p>
<p>12. Clear evidence of agency progress toward local, indigenous partner prime funding.</p>	<p>The majority of partners in South Africa are local, indigenous prime partners.</p>
<p>13. Scale up of unique identifier for patients across all sites.</p>	<p>While a policy is in place, the team should work with NDoH to speed up the rollout process. Continue to monitor NDoH's efforts to address their challenges with information systems spaces that is precluding progress. This will improve tracking from testing to ART initiation and through transfers across facilities.</p>

**Table 9. Other Requirements**

In addition to meeting the minimum requirements outlined above, it is expected that South Africa will ensure appropriate progress towards viral load management and improved use of efficient testing strategies.

<b>Requirement</b>	<b>South Africa Specific Guidance</b>
<p>1. Viral load management: Country policy updated.</p>	<p>Continue to develop a national strategic plan for scale-up of viral load access for patients at PEPFAR supported sites.</p>
<p>2. Community Health Workers</p>	<p>CHWs must be scaled immediately and optimized to support high burden areas and sites.</p>
<p>3. Screen better and test smarter: Stop over-testing.</p>	<p>Policy of optimized testing that targets patients who are at risk of HIV, including focus on index testing should be adopted and implemented by the start of COP19.</p>

## **COP 2019 Technical Priorities**

Given the significant challenge linkage and retention seen in COP 17, performance must improve in South Africa now in COP 2018 implementation. South Africa requires an urgent and transformative response in both GoSA engagement and enabling policies and PEPFAR programming to reach epidemic control by 2020. We must see positive results of the PEPFAR team's remediation actions that are being employed for COP 2018, week over week and certainly by FY 2019 Q1 data that will be reviewed when we convene in March 2019. For COP 2019, treatment targets will be straight lined from COP 2018 results. If PEPFAR South Africa demonstrates performance improvement across the clinical cascade through transformative shifts to program implementation, additive COP 2019 funds will be unlocked for FY 2020 implementation. Specifically, performance must improve across the treatment clinical cascade.

### Tuberculosis

PEPFAR OUs are expected to offer Tuberculosis Preventive Treatment (TPT) as a routine part of HIV care, which means that all care and treatment partners are expected to offer TPT and report on it. Programs are expected to fully scale TPT over the next two years, such that all PLHIV who are on treatment and are eligible for TPT have received a course by the end of COP 2020. Therefore, the TB\_PREV targets included in this letter were set as described above under the target table. For COP 2019, the number of patients that are expected to complete a course of TPT in OU is 834,022 approximately half the total number of eligible PLHIV, per the mandate from S/GAC to fully scale TPT over the next two years. COP 2020 TB\_PREV targets will cover the remaining 50% of the eligible PLHIV on ART, adjusted upward for those that will be newly enrolled in ART during the COP 2019 implementation period. In order to ensure successful programming, it is expected that, at a minimum, \$4,670,523 will be budgeted for TPT commodities.

### DREAMS

South Africa is allocated \$33,323,381 funding for DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) programming in COP 2019, of which, \$8,182,433 of your COP 19 HVAB budget code needs to be part of your DREAMS programming. This funding is allocated within your COP 2019 planning level and must be used exclusively for the goal of HIV Prevention among adolescent girls and young women (AGYW) in DREAMS SNUs in accordance with all DREAMS and COP 2019 Guidance. All new funding allocated to AGYW prevention programming, including DREAMS, must be allocated to the AGYW Prevention cross-cutting budget code.

South Africa needs to develop and implement standard criteria and SOPs for the systemic identification, enrollment, and service delivery to the most vulnerable AGYW across implementing partners and districts. The team should accelerate and finalize a tracking system for layering. A timeline for standing up the system and when it will be able to report on AGYW\_PREV should be included in the COP submission. Team should work with DREAMS implementing partners to improve layering, particularly between clinical and community partners, by ensuring that DREAMS partners are clear that they are responsible for actively

linking AGYW to the services of other partners and not just to their own. Ensure more intensive monitoring and partner management to support the practice of active linkages, rather than passive referrals across all partners. Further, the team should ensure strong partner management to eliminate inefficient practices and improve the practice of layering (e.g. door-to-door testing, not linking eligible HIV – AGYW to DREAMS and other prevention services, delivery adapted curricula not aligned to curriculum fidelity and DREAMS and COP 2019 Guidance). Lastly, the team must focus on scaling up the demand and distribution of PrEP.

VMMC

South Africa is allocated \$60,278,659 funding for VMMC. As with COP 2018, your total COP 2019 allocation to the CIRC budget code is included in your COP funding determined in this letter. VMMC funding must be used exclusively to support the implementation of VMMC programs in males 10 years and older as pursuant with the CIRC budget code guidance, including the minimum package of clinical and prevention services which must be included at every VMMC delivery point, circumcisions supply and commodities, communication and demand creation, training, and case finding and linkages for high-risk men.

South Africa’s total VMMC target for COP 2019 is 520,000 and a minimum of 306,800 circumcisions should be done in men over age 14.

		COP19				
		VMMC coverage 15-24	VMMC coverage 15-49	Minimum % 15+	Minimum VMMC in 15+	
	target	Total \$				
<b>South Africa</b>	520,000	60278658.6	70	62	59	306800

Other technical and programmatic priorities for South Africa

Additionally, as previously mentioned, the following items have been identified as top priorities for COP 2019:

Linkage to Treatment

- Continue to scale up active tracking and tracing of those who don’t initiate same-day Test and Start, and those on early-, late-missed appointment lists and LTFU
- Prioritize efforts to address linkage and retention through calls and home visits
- Large percentage of patients decanted in most clinics yet loss is very high. The team needs to unpack early, late and LTFU lists and have documented outcomes to understand who is falling out.
- Ensure transfers and self-transfers are properly documented.
- Strengthen coordination between clinic and community for tracing those hardest to reach.
- Scale up plans for population-specific retention interventions.
- Accelerate efforts to stem attrition at provider, patient, and facility levels.

#### PrEP

- Leverage PrEP promotion as part of layered package for prevention programming to significantly increase PrEP results.

#### Human Resources for Health

- Continue to monitor implementation efforts for the new HMIS system developed by NDoH. Ensure the system provides better accountability and tracks the HRH support across all facilities.
- Continue to work with NDoH to improve effectiveness and impact of Community Health Workers (CHWs).

#### Partner performance

- 1<sup>st</sup> 90: Broadreach, Right to Care, HST, and Aurum are overspending and underachieving. Intensify partner management and develop remediation plans and budget implications for COP 19.
- 2<sup>nd</sup> 90: Broadreach, Aurum, HST, and Kheth'Impilo are overspending and underachieving. Intensify partner management and develop remediation plans and budget implications for COP 19.
- While not the largest partners by volume, USAID Kheth'Impilo and CDC TB/HIV significantly underperformed across the first and second 90.
- VMMC: TB/HIV also overspent and underachieved in its VMMC targets. Though the partner has not historically underperformed in this area (113% achievement in FY 2017), they must focus resources and efforts in the highest targeted districts to reach targets.
- As a result of poor partner transition and oversight, a complete transition from USAID to CDC in Tshwane has been put into effect immediately. Continue to monitor transition in COP 18 implementation. Progress on the transition should be included in all COP 19 planning efforts.
- PEPFAR South Africa is encouraged to implement performance improvement plans to remediate outstanding instances of underperformance. Attention must be directed toward improving partners' capacities to retain and re-engage persons who have been diagnosed with HIV infection and initially linked to treatment. The team is urged to identify those partners that report good results for these indicators (e.g., ANOVA), for lessons that may generalize to other partners. The team must scrutinize partner-level expenditures to ensure that performance and outlays are commensurate.

#### **COP 2019 Stakeholder Engagement**

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of COP 2019 remains a requirement for all PEPFAR programs, and as such the COP 2019 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2018 Q4 and FY 2018 APR results and analyses and the convening of an in-country planning retreat with local stakeholders

no later than the week of January 28, 2019 in order to introduce and discuss all COP 2019 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP 2019. In February, initial COP tools will be submitted to S/GAC for review and feedback. S/GAC will provide feedback prior to the in-person meetings in March and April, and teams should reflect the feedback with their revised submissions. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team.

In March 2019, PEPFAR will convene in-person meetings in Johannesburg, South Africa, where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Engagement with all stakeholders is required beyond the meetings and throughout the COP 2019 development and finalization process. As in COP 2018, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP 2019 Guidance for a full list of requirements and engagement timelines (Section 2.5.3).

Subject to COP Development and Approval